

Uterine necrosis following B-Lynch suture leading to Peripartum Obstetric Hysterectomy: Rare complication

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Objective

Postpartum haemorrhage (PPH) remains a leading cause of maternal morbidity and mortality worldwide. While uterotonic medications often suffice in managing atonic PPH, surgical interventions like compression sutures are sometimes necessary. We report a rare complication of uterine necrosis following the use of B-Lynch sutures, which necessitated an obstetric hysterectomy, highlighting the importance of meticulous technique, early detection, and appropriate follow-up.

Case Report

A 33-year-old primiparous woman underwent a lower segment cesarean section (LSCS) for dichorionic diamniotic (DCDA) twins. The surgery was complicated by intractable atonic PPH, with an estimated blood loss of 4.3 litres. Haemostasis was achieved with B-Lynch sutures and a Bakri balloon during laparotomy. She received multiple blood transfusions, IV antibiotics postoperatively, and was discharged on oral antibiotics. Twelve days later, she presented with abdominal pain, distension, low-grade fever, and difficulty walking. Examination revealed pallor, fever, tachycardia (pulse 100/min), BP 110/60 mmHg, and an indurated LSCS scar. Laboratory results showed HB of 83 g/L, leukocytosis, raised CRP (170), and elevated GGT (330). Ultrasound revealed increased ascites and sub involution of the uterus. Suspecting postpartum sepsis, an ascitic tap showed mixed inflammatory cells (50% polymorphs and 50% lymphocytes). Blood cultures were positive, though final sensitivities were pending. Imaging confirmed an unsalvageable, necrotic uterus as the source of infection. She underwent an emergency obstetric hysterectomy. Postoperative recovery in the high-dependency unit was uneventful.

Discussion

The implications of the above case in clinical practice includes:
Careful application ,necessity of meticulous technique and appropriate tension , while application of compression sutures like Modified B-Lynch in order to avoid Uterine ischemia and necrosis. Vigilant postoperative monitoring and early detection of signs of infection or uterine compromise enables timely intervention. The above case also emphasises pivotal role of imaging particularly ultrasound and MRI in diagnosing complications following uterine compression sutures, which can guide clinical decision making. In cases where Complications are suspected Prompt surgical exploration may be necessary to manage severe outcomes like necrosis and prevent further deterioration.

Conclusion

While compression sutures have revolutionised PPH management, their complications must be carefully monitored. Early follow-up and timely intervention are crucial to avoid severe sequelae such as hysterectomy and to preserve the fertility potential of affected women. This case highlights the need for refining protocols and balancing haemostasis with uterine preservation It highlights the need to refine surgical techniques and incorporate training in advanced compression sutures into residency programs to prevent such adverse outcomes.